Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TEXAS MIDWEST SURGERY CENTER 751 NORTH 18TH ABILENE, TX 79601	MFDR Tracking #: M4-09-7785-01
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Rep Box # 54	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary on DWC 60 Table: "Claim stamped 'Separate Reimbursement For Implants Requested.'"

Position Statement Letter: "We are disputing the denial for payment of implant codes L8699. The total sum billed for implants using codes L8699 is $4,617.80. These were denied stating we did not ask for separate reimbursement of implants.

Attached is a copy of the initial claim that was faxed to us by the carrier showing the claim was stamped requesting reimbursement for the implants."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $4,617.80
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The implant invoice submitted by the requestor to Texas Mutual with the initial billing has no signature. (Exhibit) For this reason Texas Mutual reimbursed the requestor 235% of the Medicare ASC rate as required by Rule 134.202 [sic] based on the failure of the requestor to meet the requirements of subsection (g) and believes no additional payment is due."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/23/08	L8699(X8)	CAC-W1, CAC-W4, CAC-89, 626, 891, 892	1-6	$4,617.80
Total /Due:				$4,617.80

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:

   - "Reimbursed denied in accordance with Rule 134.402(F)(1). Separate reimbursement for implantables was not requested by the facility in accordance with Rule 134.402(G). Payment was allowed at the higher multiplier of 235% on the initial audit;
   - CAC-W1- Workers Compensation Fee Schedule Adjustment;
   - CAC-89-Professional fees removed from charges;
   - 626-The non-facility portion has already been processed, this allowance is for the facility portion;
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration;
   - 891-The insurance company is reducing or denying payment after reconsideration; and
   - 892-Denied in accordance with DWC Rules and/or Medical Fee Guideline."

2. The Requestor submitted the CMS-1500 dated 10-29-08 that was faxed to them by the insurance carrier that is stamped "Separate Reimbursement to ASC for implantables requested." Therefore, the Requestor supported their position that separate reimbursement for implantables was requested.

3. The 10/23/08 operative report indicates the claimant underwent the following:

   - "Attempted and aborted open reduction and internal fixation left elbow radial head fracture; and
   - Radial head replacement."

4. The Respondent indicated in their position statement that they did not reimburse the Requestor separately for the implantables because the invoice with the initial claim was unsigned. The Requestor provided a signed invoice to the Division in accordance with Rule 134.402(g)(1)(B). Therefore, the Division will review this dispute in accordance with Rule 134.402(f).

5. Per Rule 134.402(f) reimbursement for non-device intensive procedure for CPT code 24666-LT is:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = $3,772.17. The national reimbursement is divided by 2 = $1,886.09 ($3,772.17/2).

   This number X City Conversion Factor/CMS Wage Index for Abilene $1,886.09 X 0.7957 = $1,500.76.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $1,500.76 + $1,886.09 = $3,386.85.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $3,386.85 X 153% = $5,181.88.

   The MAR for CPT code 24666-LT when separate reimbursement for implantables is sought is $5,181.88.

6. Per Rule 134.402(f)(1)(B) reimbursement for implantables is "(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10% of $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." The Requestor billed for eight (8) implantables utilizing HCPCs code L8699 for a total of $4,617.80. Per Rule 134.402(f)(1)(B)(i), the Requestor is due $4,617.80 based upon:

HCPCs Code	Invoice Amount	MAR
L8699	$2,000.00	$2,200.00
L8699	$1,250.00	$1,375.00
L8699	$750.00	$825.00
L8699	$33.00	$36.30
L8699	$33.00	$36.30
L8699	$33.00	$36.30
L8699	$33.00	$36.30
L8699 X2	$66.00	$72.60

The MAR for the admission is $9,799.68. The insurance carrier paid $5,173.38. The difference between amount due and paid equals $4,626.30. The Requestor is seeking a lesser amount of $4,617.80; this amount is recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$4,617.80** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	10/2/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.